Covered Services and Limitations

The rules, regulations, and policies described in this manual apply to the services provided by Dentists, Denturists, Orthodontists, and oral surgeons. Providers may be reimbursed for Medicaid covered services when the following requirements are met:

- Provider must be enrolled in Medicaid. (ARM 37.85.402)
- Services must be performed by practitioners licensed and operating within the scope of their practice as defined by law. (ARM 37.85.406)
- Client must be Medicaid eligible and non-restricted. (ARM 37.85.415)
- Service must be medically necessary. (ARM 37.85.410) (The Department may review medical necessity at any time before or after payment.)
- Service must be covered by Medicaid and not be considered cosmetic, experimental or investigational. (ARM 37.85.415)
- Charges must be usual and customary. (ARM 37.85.212)
- Claims must meet timely filing requirements. (ARM 37.84.406)
- Prior authorization requirements must be met. (ARM 37.86.1006)
- Passport approval requirements must be met.

Who is eligible for dental services?

1. Clients who have "Full" indicated on their Medicaid ID card.

2. Clients age 21 and over are eligible for only diagnostic, preventative, basic restorative (including stainless steel crowns), dentures (immediate, full and partial), and extraction services (ARM 37.86.1006). Please review the most recent Department dental fee schedule for specific code coverage available for individuals over the age of 21.

3. Pregnant women who present a *Presumptive Eligibility Notice of Decision*. Providers should call 1-800-932-4453 to verify presumptive eligibility.

4. The **only** time clients who have "Basic" on their Medicaid ID cards are eligible for dental coverage is when:
   - Emergency dental services are necessary.

Preventative treatments or routine restorative services are specifically excluded from any emergency dental services under "Basic" Medicaid.

Medicaid may cover emergency dental services for those clients who are on "Basic" Medicaid. Subject to the dental program limitations, the Medicaid program will reimburse dental providers for palliative treatment and diagnostic services related to the treatment of emergency medical conditions. Root canals are allowable on anterior teeth only. When billing for emergency services, claim must be accompanied by a completed *Emergency Dental Services Authorization Form for Adult FAIM Clients on Basic Medicaid* form located in Appendix A.

- Dental work is "Essential for Employment".
  In limited circumstances, Medicaid will cover a service normally excluded under "Basic" Medicaid if it is essential to obtaining or maintaining employment. When this is the case, the client will present a signed form (FA-782). Prior to receiving dental services as an "Essential to Employment" benefit, the client must obtain the FA-782 form through their eligibility specialist at their local county office of public assistance. This form must be submitted with the dental claim.

  Routine dental services (i.e., exam, x-rays and prophylaxis) are not covered services under the Essential for Employment program. Reimbursement is the same for approved services as they would be for a Full Medicaid client.

  Send both the completed *Emergency Dental Services Authorization Form for Adult FAIM Clients on Basic Medicaid* and the FA-782 forms to the Dental Program Officer (see *Key Contacts*).

Services and limitations (ARM 37.86.1006)

The following are Medicaid covered services and limitations.

1. Diagnostic
   The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, diagnosis, and treatment planning are the responsibility of the dentist. As with all ADA procedure codes, there is no distinction made between the evaluations provided by general practitioners or specialists.

   Examinations for adults will be allowed every six months or more often if a referral has occurred. If both the dentists involved in the referral have done full exams, both can be paid. For this exception to be made, the providers must both indicate on their claims that a referral has occurred and the name of the other dentist involved. This information should be reported in the field 31/38 of the ADA claim form. If you have a denial of the referral visit, please review your claim form to ensure you have the referring dentist's name and resubmit

for payment. If you have a copy of your claim and the referring dentist's name is listed, please call Provider Relations (see *Key Contacts*) for a request to reprocess this claim.

2. Radiographs
   Radiographs should be taken only for clinical reasons as determined by the client's dentist. They should be of diagnostic quality and properly identified and dated. They are considered to be part of the client's clinical record.

   If additional panoramic films are needed for medical purposes (i.e: to check healing of a fractured jaw), they can be billed on an ADA form as long as it was done in an office setting. Otherwise, they should be billed on the CMS-1500 (formerly HCFA-1500) claim form using the CPT-4 code 70355 for panoramic x-ray.

3. Dental prophylaxis, fluoride treatment, and sealants
   Procedure code D1110 or D1205 will be allowed once every six months, and providers may bill for either code. Payment will **not** be made for both procedures within a six-month period. If providers are treating individuals with a developmental disability who require a prophylaxis treatment more often than six months intervals, write "handicapped" or "developmentally disabled" in box 31 or 38 on the ADA claim form.

   Sealants are limited to individuals age 20 and under, and are only allowed for a limited number of teeth (# 2, 3, 14, 15, 18, 19, 30, 31, A, J, K, & T). Retroactive review will be done to determine compliance with this policy.

4. Restoration
   For complete restoration of a tooth (filling of all surfaces currently damaged by caries), the following policies apply:

   - When more than one surface is involved, and one continuous filling is used, select the appropriate code from the range of D2110 through D2385.

   - When there are separate fillings on each surface, the one-surface codes are to be used, (D2110, D2140, D2330, D2380, D2385). Your records must clearly indicate each filling is treatment for a separate cavity.

   - The ADA views restorative work done on the same day and same tooth as one tooth with five surfaces.

     1. Only one payment will be allowed for each surface.

2. When more than one filling is included on a surface, combine the code. For example, MO and LO on a permanent molar restored in the same day should be coded as MOL. This should be coded this way whether the filling on the occlusal is a continuous filling or two separate fillings. The ADA views work done on the occlusal as one of the five surfaces that are billable.

3. When more than one filling is included on a surface and restored on different days, they should be coded on different days. For example if MO and LO on a permanent molar are restored on subsequent days, they should be coded as a MO on the first day and LO on the second day.

   If post payment review identifies erroneous payments made for additional fillings on the same surface as part of the same treatment, the over payments will be recovered.

- Amalgam restorations (including polishing)
  All adhesives (including amalgam bonding agents), liners, and base, are included as part of the restoration. If pins are used, they should be reported separately (see procedure code D2951).
- Silicate and resin restorations
  Resin refers to a broad category of materials including, but not limited to, composites. Also included may be bonded composite, light-cured composite, etc. Light-curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. If pins are used, they should be reported separately.

5. Tooth-colored crowns (Ages 20 and under only)
   Crowns are limited to situations where the tooth is periodontally healthy and without pulpal pathology and the tooth cannot be restored by any means other than a full coverage restoration. Tooth colored full coverage crown restorations are only available for anterior teeth (6-11 and 22-27). Crowns on posterior teeth are limited to prefabricated resin and/or prefabricated stainless steel, except when necessary for partial denture abutments. Indicate in the "Remarks" section of the claim form which teeth are abutment teeth. Crowns are limited to one, per tooth, every five years.

   Pre-fabricated stainless steel and resin crowns on all teeth are available for individuals with "Full" Medicaid coverage.

6. Canal therapy
   Canal therapy includes primary teeth without succedaneous teeth and permanent teeth.

Complete root canal therapy. Pulpectomy is part of root canal therapy. It includes all appointments necessary to complete treatment and intra-operative radiographs. It does not include diagnostic evaluation and necessary radiographs/diagnostic images.

Pulpotomy (covered for ages 20 and under only) cannot be billed on the same day as endodontic therapy for the same tooth. Per guidance from the American Dental Association coding department, code D3220 should never be billed if a root canal is to be performed by the same provider.

7. Apicoectomy/periradicular services (Ages 20 and under only)
   Periradicular surgery is a term used to describe surgery to the root surface such as apicoectomy, repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. This does not include retrograde filling material placement.

8. Prosthodontics (Ages 20 and under only)
   A partial denture five years or older may be replaced by full and/or partial dentures. Full dentures, ten years old or older, may be replaced when the treating dentist documents the need for replacement. Payment for the denture includes payment for any tissue conditioners provided. Complete and partial dentures include routine post delivery care.

   Medicaid will replace lost dentures with a lifetime limit of **one** set. The claim form must include the age of the lost dentures and the term "Lost Dentures" written in the remarks section of the claim.

   The above limits may be exceeded when the dentist and the Department consultant agree the current dentures are causing the client serious physical health problems. In these situations, the provider should submit a prior authorization request. See Chapter 3, *Prior Authorization*.

9. Prosthodontics, fixed (Ages 20 and under only)
   Tooth colored, fixed partial denture pontics are only available for anterior teeth (6-11 and 22-27). Fixed partial denture pontics are not allowed for posterior teeth unless used to replace an anterior tooth. As an example, if tooth number 6 is missing, the fixed denture pontic will cover teeth numbers 5 – 7. In this example, tooth number 5 can be tooth colored. In cases where a posterior tooth is to be replaced, a partial denture must be used. Please review item number 8, *Prosthodontics* for information regarding partial dentures. Fix partial denture pontics are limited to one, per tooth, every five years.

10. Oral Surgery
    Payment for impacted third molars or supernumerary teeth will be authorized only when they are symptomatic; that is, causing pain, infected, preventing proper alignment of permanent teeth or proper development of the arch.

    Providers may use CPT-4 procedure codes for **medical** services provided in accordance of practice permitted under state licensure laws and other mandatory standards applicable to the provider. Medical services are those that involve the structure of the mouth (i.e. jaw bone). Any services involving the tooth, are considered **dental** services. Medical services can be billed on an ADA form as long as the services were provided in an office. If the procedures were done in a hospital or nursing facility setting, they must be billed on the CMS-1500 (formerly HCFA-1500) claim form with valid CPT-4 procedure codes and valid ICD-9-CM diagnosis codes. Providers who frequently bill for medical services should obtain a copy of the physician's provider manual and CMS-1500 billing instructions. These manuals are available through Provider Relations (see *Key Contacts*).

    These procedures will be reimbursed through the resource based relative value scale (RBRVS) fee schedule. All CPT-4 codes billed will comply with rules as set forth in the Administrative Rules of Montana (ARM) for physicians. General anesthesia is listed in the CPT-4 procedures codes and must be billed using a CMS-1500 (formerly HCFA-1500) claim form.

11. Surgical extractions
    Surgical extractions include local anesthesia and routine postoperative care.

12. Denture services
    - A dentist's prescription is required in the following circumstances:
      - All partial denture work.
      - All immediate denture work.
    - Limitations or requirements for the dental codes are listed in the following section, *Procedure limits and requirements*.

    A dentist's prescription is no longer required for any denture work other than what is indicated above. Denturists are responsible for ensuring the dentist's prescription is kept in the client file.

Procedure Limits and Requirements

These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D0120	Periodic oral exam	Allowed for adults every 6 months.	No
D0140	Limited oral exam – problem focused	Referral for a specific problem, emergencies, trauma or acute infections.	No
D0150	Comprehensive oral exam	This code is allowed for **new** clients of record for their initial visit.	No
D0210	Intraoral- complete series (including bitewings) (Minimum of 14 films)	• **1 film = 1 unit of service** • Adults are allowed every 3 years. Call Provider Relations to verify if Medicaid has paid within the past 3 years. • Limit does not apply to those age 20 and younger.	No
D0270	Bitewing- single film	• Adults are limited to 4 films per year. • Limit does not apply to those age 20 and younger.	No
D0272	Bitewings - two films	• **2 films = 1 unit of service** • Adults are limited to 4 films per year. • Limit does not apply to those age 20 and younger.	No
D0274	Bitewings - four films	• **4 films = 1 unit of service** • Adults are limited to 4 films per year. • Limit does not apply to those age 20 and younger.	No
D0330	Panoramic film	• Adults are limited to one film every three years. • Limit does not apply to those 20 yrs & under.	No
D0340	Cephalometric film		Ages 20 and under only
D0350	Oral/facial images		Ages 20 and under only
D0460	Pulp vitality tests		Ages 20 and under only
D0470	Diagnostic models – also known as diagnostic casts or study models		Ages 20 and under only
D1110	Prophylaxis – adult	Allowed every 6 months.	No
D1205	Topical application of fluoride (including prophylaxis) – adult	Allowed every 6 months.	No

Procedure Limits and Requirements (continued)

These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D1351	Sealant - per tooth	• # 2, 3, 14, 15, 18,19, 30, 31, A, J, K, T • Limited to individuals age 20 and under.	Ages 20 and under only
D2951	Pin retention-per tooth, in addition to restoration	Maximum two units per tooth.	Ages 20 and under only
D3220	Therapeutic pulpotomy (excluding final restoration) Performed on primary or permanent teeth.	No additional fee will be paid for pulp capping or bases.	Ages 20 and under only
D3230	Pulpal Therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)		Ages 20 and under only
D3240	Pulpal Therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	• For primary second molars (A, J, K, T). • Only allowed if 6 year Molar is not erupted or permanent second pre-molar is congenitally absent.	Ages 20 and under only
D4210	Gingivectomy or gingivoplasty (Per quadrant)	• Limited to cases involving gingival hyperplasia due to medication reaction or pregnancy. • Quadrants should be listed in the "**Tooth Number**" column as follows: LL – Lower Left UL – Upper Left LR – Lower Right UR – Upper Right	Ages 20 and under only
D4341	Periodontal scaling and root planing (Per quadrant)	• **1 quadrant = 1 unit of service.** • Providers are allowed to bill up to 4 quadrants every year. • Must scale and root plane at least 4 teeth per quadrant with documented pocket depths of at least 4 mm in the medical history file. • Allowed once per year. • Quadrants should be listed in the "**Tooth Number**" column as follows: LL – Lower Left UL – Upper Left LR – Lower Right UR – Upper Right	No

Procedure Limits and Requirements (continued)

These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis.	• To be used prior to periodontal scaling and root planing only if provider cannot determine extent of periodontal scaling and root planing without this procedure. • Limited to once per year if medically indicated.	No
D4910	Periodontal maintenance procedures	• To be used after initial periodontal scaling and root planing completed. • Limited to once every three months if medically indicated.	No
D5110	Complete upper	Call Provider Relations to verify if Medicaid has paid dentures within the past 10 years.	No
D5120	Complete lower	Call Provider Relations to verify if Medicaid has paid dentures within the past 10 years.	No
D5130	Immediate upper	• Includes limited follow-up care only. • Does not include required future rebasing/relining procedures.	No
D5140	Immediate lower	• Includes limited follow-up care only. • Does not include required future rebasing/relining procedures.	No
D5211	Maxillary partial denture – Resin Base (including any conventional clasps, rests and teeth)	• Includes acrylic resin base denture with resin or wrought iron clasps. • Partial dentures will only be replaced every 5 years.	No
D5212	Mandibular partial denture – Resin Base (including any conventional clasps, rests and teeth)	• Includes acrylic resin base denture with resin or wrought iron clasps. • Partial dentures will only be replaced every 5 years.	No
D5213	Maxillary partial denture – Cast metal framework with resin denture bases	• Includes any conventional clasps, rests and teeth. • Partial dentures will only be replaced every 5 years.	No
D5214	Mandibular partial denture – Case metal framework with resin denture bases	• Includes any conventional clasps, rests and teeth. • Partial dentures will only be replaced every 5 years.	No
D5820	Interim partial denture (maxillary)	• Use of a flipper is considered a partial denture. • Partial dentures will only be replaced every 5 years.	Ages 20 and under only

Procedure Limits and Requirements (continued)

These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D5821	Interim partial denture (mandibular)	• Use of a flipper is considered a partial denture. • Partial dentures will only be replaced every 5 years	Ages 20 and under only
D5410	Adjust complete denture – upper	• The first 3 adjustments after dentures are placed are included in the denture price. • Any additional or yearly adjustments can be billed using this code.	No
D5411	Adjust complete denture – lower	• The first 3 adjustments after dentures are placed are included in the denture price. • Any additional or yearly adjustments can be billed using this code.	No
D5421	Adjust partial denture – upper	• The first 3 adjustments after dentures are placed are included in the denture price. • Any additional or yearly adjustments can be billed using this code.	No
D5422	Adjust partial denture – lower	• The first 3 adjustments after dentures are placed are included in the denture price. • Any additional or yearly adjustments can be billed using this code.	No
D5520	Replace missing or broken teeth – complete denture (each tooth).	Each additional tooth needs to be billed on separate lines with the tooth number indicated in the tooth number column.	No
D5610	Repair resin saddle or base	No teeth or metal involved.	No
D5710	Rebase complete upper denture (jump or duplicate)	Dentures must be 5 years old or older.	No
D5711	Rebase complete lower denture (jump or duplicate)	Dentures must be 5 years old or older.	No
D5720	Rebase upper partial denture (jump or duplicate)	Dentures must be 5 years old or older.	No
D5721	Rebase lower partial denture (jump or duplicate)	Dentures must be 5 years old or older.	No
D7110	Single tooth extraction	Includes local anesthesia, suturing, if needed, and routine postoperative care.	No

Procedure Limits and Requirements (continued)

These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D7120	Each additional tooth	To be reported for an additional extraction in the same quadrant at the same visit.	No
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Includes cutting of gingiva and bone, removal of tooth structure, and closure.	No
D7220	Removal of impacted tooth – soft tissue	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.	No
D7230	Removal of impacted tooth – partially bony (crown of tooth is partially covered by bone)	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.	No
D7240	Removal of impacted tooth – completely bony (crown of tooth is completely covered by bone)	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.	No
D7250	Surgical removal of residual tooth roots (cutting procedure)	Includes cutting of soft tissue and bone, removal of tooth structure and closure.	No
D7310	Alveoloplasty in conjunction with extractions (Per quadrant)	Indicate quadrant in "**Tooth Number**" column: LL – Lower Left UL – Upper Left LR – Lower Right UR – Upper Right	No
D7320	Alveoloplasty not in conjunction with extractions (Per quadrant)	Indicate quadrant in "**Tooth Number**" column: LL – Lower Left UL – Upper Left LR – Lower Right UR – Upper Right	No
D7340	Vestibuloplasty – ridge extension	Secondary epithelialization.	Ages 20 and under only
D7350	Vestibuloplasty – ridge extension	Include soft tissue graft, muscle re-attachment, revision & management of tissue.	Ages 20 and under only

Procedure Limits and Requirements (continued)
These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D7540	Removal of reaction-producing foreign bodies – musculosk-eletal system	May include, but not limited to, removal of splinters, pieces of wire etc., from muscle and/or bone.	No
D7550	Sequestrectomy for Osteomyelitis	Removal of loose or sloughed-off dead bone caused by infection or reduced blood supply.	No
D7911	Complicated suture – up to 5 cm	• Reconstruction requiring delicate handling of tissues and wide under-mining for meticulous closure. • Excludes closure of surgical incision.	No
D7912	Complicated suture – greater than 5 cm	• Reconstruction requiring delicate handling of tissues and wide under-mining for meticulous closure. • Excludes closure of surgical incision.	No
D7920	Skin graft	Identify defect covered, location, and type of graft.	Ages 20 and under only
D7970	Excision of hyper-plastic tissue, per arch	For edentulous client.	Ages 20 and under only
D9230	Nitrous Oxide	Covered for children age 12 and under.	Ages 12 and under only
D9110	Palliative (emer-gency) treatment of dental pain – minor procedures	Writing prescriptions, occlusal adjustments, emer-gency examinations, and instructions for home care are not included.	No
D9241	IV Sedation (first 30 minutes)	May only be used if the client is physically or emo-tionally unable to undergo the proposed treatment or procedures using local anesthesia alone or in conjunc-tion with oral sedation and/or nitrous oxide.	No
D9242	IV Sedation (each additional 15 minutes)	See limitations under procedure code D9241.	No
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	Includes specialist consultation; should not be reported to describe discussion of treatment plan.	No

Procedure Limits and Requirements (continued)

These codes include only procedures that have a descriptive limitation or requirement.

Code	Procedure Description	Limitation or Requirement	Age Restrictions
D9410	House call (also used for nursing home visits)	One nursing home call per day even when multiple clients are seen.	No
D9420	Hospital call	This hospital call code is to be used when a dentist is called to the hospital emergency room or if not billing Z0055.	No
Z0055	Scheduled hospital dental visit	• Hospital visit allowed if the client is unable to be managed in the office or is medically unstable. • Medical necessity must be documented in the client file. • Can only be billed one time (per day), this procedure is to cover the time for equipment to be set up at the hospital.	No
D9920	Behavior management Billed in 15 minute units (max 4 units per visit)	• 15 min = 1 unit of service. • Code can only be billed where an office treatment requires extraordinary effort and is the only alternative to general anesthesia. • Includes any and all pharmacological, psychological, physical management adjuncts required or utilized. • Limit of 12 units per year.	No

Date of service

Date of service is the date a procedure is completed. However, there are instances where Medicaid will allow a date other than the completion date.

If a denture is inserted during a month when the client is not eligible, but previous work (including laboratory work) was completed during an eligible period, the denture claim will be allowed to be billed using the impression date rather than the seating date as the date of service.

If a crown or bridge has been sent to the laboratory for final processing, and the client never shows for the appointment to have the final placement, providers may bill the date of service as the date the crown or bridge was sent to the laboratory for final processing. However, the client must have Medicaid eligibility at the time crown or bridge is sent to the lab. Crowns and bridges are limited to clients age 20 and under.

If a provider has opened the area for a root canal but anticipates the client will not return for completion or is referring client to another provider for root canal completion, procedure D3220 (covered for ages 20 and under only) may be billed. However, root canal codes must be billed to Medicaid at the time of completion.

Fee schedule

All procedures listed in the Montana Medicaid Fee Schedule are covered by the Medicaid program and must be used in conjunction with the limits listed in the previous section (*Procedure limits and requirements*). If CDT-3 codes exist and are not listed in the Montana Medicaid Fee Schedule, the items are not a covered service of the Medicaid program. Services that are not covered or exceed the specified limits can be billed to the client as long as the provider informs the client, prior to providing the services, that the client will be billed. Fee schedules are available on disk, hardcopy, or on the internet. For disk or hard copy, contact Provider Relations (see *Key Contacts*). The internet address for fee schedules is as follows:

www.dphhs.state.mt.us/hpsd/medicaid/medpi/medfs/medfs.htm

Calculating service limits

Service limits do not apply to individuals up to and including age 20.

Any service which is covered only at specified intervals for adults will have a notation next to the procedure code with information about the limit (refer to previous section *Procedure limits and requirements)*. When scheduling appointments, please be aware limits are controlled by our computerized claims payment system in this manner.

Limits on these services are controlled by matching the date on the last service against the current service date to assure the appropriate amount of time (six months, one year, or three years) has elapsed.

For example, if an adult received an examination on February 27, and the same service was provided again on February 26 of the following year, the claim would be denied as a complete year would not have passed between services. If the service were provided on February 27 of the following year, or after, it would be paid.

Providers should call Provider Relations (see *Key Contacts*) to get the last date of service for those procedure codes with time limits or other limitations of dental services. This information will allow the provider to calculate service limitations, but it does not guarantee payment of service for service-limited procedures. In certain circumstances, prior authorization may be granted for services when limits have been exceeded. See Chapter 3, *Prior Authorization*.

EPSDT services for individuals age 20 and under

Limits on medically necessary services (e.g., exams, prophylaxis, x-rays, etc.) do not apply to clients age 20 and younger as part of the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. Medicaid has a systematic way of exempting children from the service limits. Therefore, providers no longer need to indicate "EPSDT" on the claim form for the limits to be overridden.

If you are providing a procedure not listed in the Montana Medicaid fee schedule to a child and it is medically necessary, please contact the Dental Program Officer (see *Key Contacts*) for claims processing instructions.

Non-covered services

1. Tooth-colored crowns and bridges are not covered for clients 21 years of age and older.

2. No-show appointments
   "No-show" appointment occurs when a client fails to arrive at a provider's office for a scheduled visit and did not cancel or reschedule the appointment in advance. "No-show" appointments are not a covered service and cannot be billed to Medicaid.

3. Cosmetic dentistry
   Medicaid does not cover cosmetic dental services.

4. Splints/mouthguards
   Splints and mouth guards are not a covered service of the Medicaid program.

5. Qualified Medicare Beneficiary (QMB)
   Medicaid does not cover dental services for clients that have "QMB" on their Medicaid ID card. See *General Section*, *Chapter 3, Client Eligibility and Responsibilities* for more information on QMB.

6. Basic Medicaid Coverage
   Dental services are not covered for clients that have "Basic" on their Medicaid ID card. However, the client may be eligible for emergency services (see *Who is eligible for dental services?* at the beginning of this chapter).

7. Dental implants are not covered by the Medicaid program.

Billing Procedures

Timely Filing (ARM 37.85.406)

Providers are required to submit a clean claim no later than 365 days from:

- The date of service.
- The date retroactive eligibility is determined.
- The date disability is determined.

A "clean claim" is one that can be adjudicated without correction, additional information, or documentation from the provider.

A claim is considered "submitted" on the date it was stamped "received" by the Claims Processing Unit or the Department. A claim lost in the mail is not considered received.

To avoid a denial because the timely filing deadline was missed, providers may bill Medicaid when another insurance was billed and 90 days have passed with no response.

Usual and customary charges

All charges for services submitted to Medicaid must be made in accordance with an individual provider's "usual and customary" charges to the general public unless:

1. A provider has entered into an agreement with the Department to provide services at a negotiated rate.

2. A provider has been directed by the Department to submit charges at a Department specified rate.

The usual and customary charge is the price the provider most frequently charges the general public for the same service. In determining "usual and customary" prices, the Department:

- Does not include services paid by third party payers, including health insurers, governmental entities, and Montana Medicaid, in the "general public".
- Includes discounts advertised or given (including but not limited to cash rebate, monetary price discount, coupon of value) to any segment of the general public.

When submitting claims to Medicaid, please bill using your usual and customary charges, not the Medicaid reimbursement fee.

- Uses the lower of the two pricing policies if a provider uses different pricing for "cash" and "charge" clients.
- Will use the median price if during an audit, the most frequent price cannot be determined from provider records.

When can I bill a Medicaid client? (ARM 37.85.406)

Medicaid clients may be billed:

- When the client has exceeded the Medicaid limits on office or outpatient hospital visits. For information on limits, see Chapter 1, *Covered Services and Limitations*.
- When the services are not covered by Medicaid or are not medically necessary or cost effective. The provider must explain that the client will be responsible to pay for the non-covered services, and both parties agree in writing **before** rendering the service.
- For co-payments.

Providers shall **not** bill a client:

- For the difference in charges and the amount Medicaid paid.
- For a service that has not been billed to Medicaid.
- When a third-party insurance company does not respond.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.

Billing retroactively eligible clients

When a client becomes retroactively eligible for Medicaid, the provider may choose whether or not to accept the client as a Medicaid client. The provider may also choose to begin billing services from the current date, or go back to the client's retroactive eligibility date. If the provider accepts the retroactive date, and the patient has been billed for the services, the provider must:

- Refund any payment the client has made to the client before billing Medicaid.
- Credit any payment made by a third party payer to that payer when billing Medicaid.

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Client cost sharing for dental services is 5% of the Medicaid allowed amount. Clients are responsible for cost sharing for Medicaid-covered services to a maximum of $500 per fiscal year except for the following:

- Children under 21 years of age

- Pregnant women
- Nursing facility residents

Providers may choose to collect client copayment at the time of service or bill the client later. According to federal regulation, a provider cannot deny services to a Medicaid client due to the client's inability to pay the co-payment at the time services are rendered. However, the client's inability to pay the copayment at the time services are rendered does not lessen the client's obligation to pay the copayment.

Submitting a claim

Billing for dental and medical services

- Dental services are any services involving a tooth. Dental services are billed using the current CDT-3 procedure codes.
- Medical services are those that involve the structure of the mouth (i.e. jaw bone).
- Providers may use CPT-4 procedure codes for all medical services they are allowed to provide under their practice act. CPT-4 procedures that are performed in the dental office may be billed on the ADA claim form. Those services provided outside the dental office must be billed on the CMS-1500 (formerly HCFA-1500) claim form with valid CPT-4 procedure codes and valid ICD-9-CM diagnosis codes. Providers who frequently bill for medical services should obtain a copy of the *Physician Related Services* manual for billing instructions. These manuals are available through Provider Relations (see *Key Contacts*).

Paper Claims

All claims must be submitted on the 1990, 1994 or 2000 version of the American Dental Association (ADA) claim form using the current CDT-3 procedure codes. Send all completed PA request forms and completed claim forms to the following address:

Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

Electronic Claims

For providers who submit claims electronically through ACE$, support is available 8 a.m. to 5 p.m. weekdays. Contact Provider Relations for support (see *Key Contacts*). See the General Section, *Provider Requirements, Electronic Claims Submission* for more information on ACE$.

Billing Tips

- ADA procedure codes must be used for dental services. The complete code descriptions, and definitions of appropriate circumstances for billing each code, are published in the ADA CDT-3 book. Additional limitations

Claims will deny if any of this information is missing.

and requirements specific to Montana Medicaid are published in Chapter 1, *Covered Services and Limitations*.

- There are certain mandatory items on each dental claim, these include:
    - Provider ID
    - Patient Name
    - Patient ID
    - Provider's Signature
    - Billed Date

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